

BEAUFORT COUNTY SCHOOLS

AUTHORIZATION FOR ATHLETIC PARTICIPATION

PLEASE PRINT ALL INFORMATION

/ / / /

Name of Student-Athlete _____ Grade _____ Sex _____ Age _____ Race _____ Date of Birth _____ Student ID Number _____

Parent/Guardian Name (First and Last) _____

Street Address _____ City _____ Zip _____ Phone: Home _____ Work _____ Cell _____

First and Last Name of Emergency Contact Person _____ Phone: Home _____ Work _____ Cell _____

Request for Permission: We, the undersigned student and the student's parent/guardian, apply for permission to participate in interscholastic athletics in the following sports:

<input type="checkbox"/> Basketball	<input type="checkbox"/> Football	<input type="checkbox"/> Softball	<input type="checkbox"/> Track
<input type="checkbox"/> Baseball	<input type="checkbox"/> Golf	<input type="checkbox"/> Swimming	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Cross Country	<input type="checkbox"/> Soccer	<input type="checkbox"/> Tennis	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Student Trainer		

General Requirements: We have read and discussed the general requirements for middle school or high school athletic eligibility. We understand additional questions or specific circumstances should be directed to my student's coach, athletic director, or principal.

1. The Beaufort County Board of Education requires that all students participating in middle school or high school athletics have adequate health and hospitalization insurance coverage. In an effort to help the students the Board purchases insurance that is secondary insurance. It is used after the athlete's home insurance is applied. There are limitations in the Student Accident Insurance coverage. It will not always pay all of the charges incurred for each student. Read the attached description of the current Student Accident Insurance policy carefully and be sure you understand it.

2. Neither the Beaufort County Board of Education nor any of its employees will be responsible for claims resulting from injury to your child while he or she is participating in any school athletic program. This means that you will be responsible for any medical treatment not covered by the Student Accident Insurance or by any health and hospitalization insurance you might have.

3. By the nature, participation in Interscholastic Athletics includes risk of injury, which ranges in severity from minor to disabling to even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate all risk. Participants can and have the responsibility to help reduce the chance of injury. Players must obey all safety rules, report all physical problems to their athletic trainers and coaches follow a proper conditioning program, and inspect their equipment daily. BCS will provide a required baseline concussion assessment before participation in a sport free of charge. This information will be collected in a confidential manner and will be shared only with the appropriate school personnel and the athlete's medical provider when requested.

4. The pre-participation examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam screens for common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician. Additionally, your child's regular health care, routine physical examinations, and a laboratory testing should continue to come from his/her personal physician.

5. I authorize the Beaufort County School District to conduct a urinalysis test for drug and/or alcohol use. I also authorize the Beaufort County School District to conduct random drug testing during the current school year and subsequent years of middle/high school with the understanding that the student can request omission from the database according to XVII C-2.

By signing this permission form, we acknowledge that we have read the above information. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE ABOVE WARNINGS SHOULD NOT SIGN THIS PERMISSION FORM.**

I hereby give my consent for _____ (name of athlete) to:

- ☒ Represent his/her school in approved athletic activities that are checked above;
- ☒ To accompany any school team of which he/she is a member of on local and out-of-town trips;
- ☒ To receive through a medical doctor of the school's choice, emergency medical care which may become reasonably necessary in the course of such athletic events or such travel.
- ☒ To receive a baseline concussion assessment before participation by authorized school personnel.
- ☒ To authorize the Beaufort County School District to conduct random drug testing.

I have read the material in this booklet and will abide by the principal and regulations contained herein.

Signature of Parent/Guardian _____ Date _____

Signature of Student/Athlete _____ Date _____

Chocowinity Middle School Athletic Guidelines

Athletics are a part of the extracurricular program at CMS. Whether on the field or floor as a contestant, or in the classroom as a student, an athlete's conduct in and out of school should:

- reflect credit upon the school;
- create a positive influence on the discipline, good order, moral and educational environment in the school, and
- meet the eligibility requirements established by the school.

Athletic Eligibility

Students must meet the following requirements in order to participate on an athletic team:

- All first-time 6th grade students will be eligible to try out for fall sports.
- Eligibility for fall sports participation for 7th and 8th graders is determined by being promoted (not administratively placed).
- To remain on an athletic team, students must maintain a passing score in 2 of the 3 core classes each semester.
- 6th grade students are not eligible to participate in Football.
- Students must not turn 15 on or before August 31.
- Student must NOT have more than 10 unexcused absences in the previous semester.
- Any athlete who quits or is dismissed from a team automatically forfeits all honors, award, and rewards for that sport and will not be reimbursed any fees associated with that sport.

Athletic Discipline Policy

Student athletes often serve as role models and are generally held in high regard by other students. Consequently, the impact of student athletes' behavior, both positive and negative, may have substantial influence on peers. In addition, the actions of student athletes are a reflection of themselves, their team, their school, and their community. Therefore, the student athlete is expected to exhibit a higher standard of behavior than might be expected of other students. In order to assure student athletes conduct themselves as responsible representative of the school, student athletes are required to uphold the guidelines and team rules established by individual coaches or sponsors. Mandatory meetings will be held for each sport season at which the code of conduct will be shared with parents.

The following discipline code will be followed for all sports at Chocowinity Middle School is a student athlete's conduct results in an office referral.

In School Suspension (ISS)

1st Assignment: Will not be able to participate in any athletic event
until ISS served 2nd Assignment: Dismissal from the team for that sport's season

Out of School Suspension (OSS)

Misbehavior of a student athlete resulting in out-of-school suspension will result in the student's suspension from the team for the remainder of that sport's season. However, the principal has the authority to override suspension from team due to OSS.

Administration and Coaches have the authority to remove a player at their discretion.

Bus/Travel

- All players must ride the bus to and from games. Athletes may ride home with their parents only if prior approval has been made.
- All players must remain seated with the same gender –facing forward.
- No loud talking or horseplay.
- Headphones required with radios (not to be used or seen during class prior to trip).
- Absolutely no talking near train tracks!!
- No food, drinks, candy, gum, etc.
- Cell phones are NOT to be used during "school hours"

Student Athletic Pledge

As a student athlete, I am a role model. I understand the spirit of fair play while playing hard. I will refrain from engaging in all types of disrespectful behavior, including inappropriate language, taunting, trash talking, and unnecessary physical contact. I know the behavior expectations of my school, my conference, and the NCHSAA and hereby accept the responsibility and privilege of representing this school and community as a student athlete.

Student Athlete Parent Pledge

As a parent, I acknowledge that I am a role model. I will remember school athletics is an extension of the classroom, offering learning experiences for the students. I must show respect for all players, coaches, spectators, and support groups. I will participate in cheers that support, encourage, and uplift the teams involved. I understand the spirit of fair play and the good sportsmanship expected by our school, our conference, DPI and NCHSAA. I hereby accept my responsibility to be a model of good sportsmanship that comes with being the parent of a student athlete.

Compromiso de padres de estudiantes atletas

Como padre, reconozco que soy un modelo a seguir. Recordaré que el atletismo escolar es una extensión del salón de clases, ofreciendo experiencias de aprendizaje para los estudiantes. Debo mostrar respeto por todos los jugadores, entrenadores, espectadores y grupos de apoyo. Participaré en aplausos que apoyen, alienten y eleven a los equipos involucrados. Entiendo el espíritu de juego limpio y el buen espíritu deportivo que espera nuestra escuela, nuestra conferencia, DPI y NCHSAA. Por la presente acepto mi responsabilidad de ser un modelo de buen espíritu deportivo que viene con ser el padre de un estudiante atleta.

Signature of Parent/Guardian: _____

Date: _____

Signature of Student/Athlete: _____

Date: _____

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print) _____

Parent/Legal Custodian Name(s): (please print) _____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

Signature of Student-Athlete

Date

Signature of Parent/Legal Custodian

Date



Student-Athlete COVID Questionnaire

Student-Athlete's Name: _____

Date of Birth: _____ Age: _____

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, OR have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?			
2. If the answer to 1 was "Yes", has the required <i>Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics</i> been completed?			
3. Have you been fully vaccinated against COVID?			



■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	



■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/____ L 20/____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

